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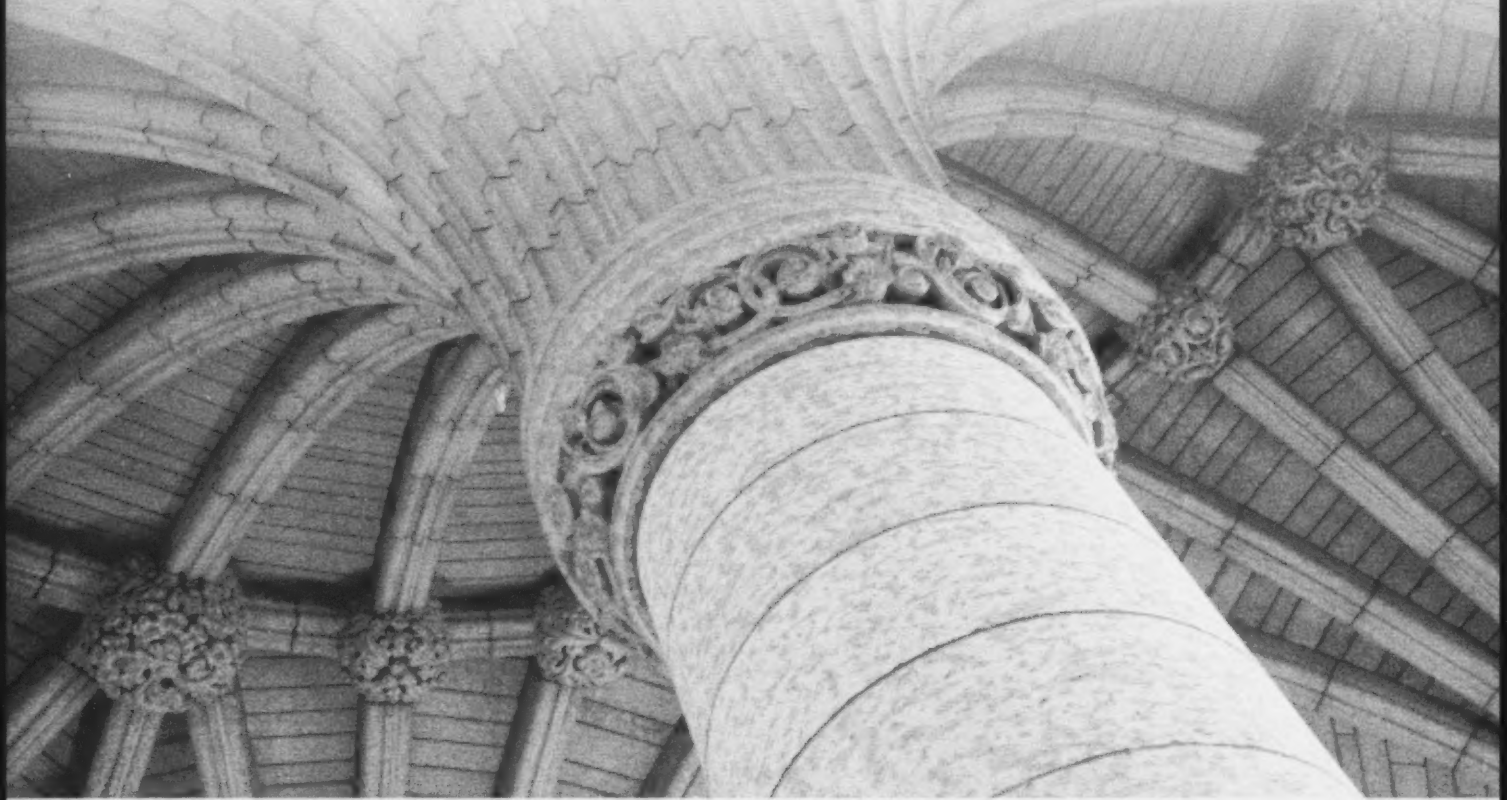
REPORT 4, ORAL HEALTH PROGRAMS FOR FIRST NATIONS AND INUIT—HEALTH CANADA, OF THE 2017 FALL REPORTS OF THE AUDITOR GENERAL OF CANADA

Report of the Standing Committee on Public Accounts

The Honourable Kevin Sorenson, Chair



MAY 2018
42nd PARLIAMENT, 1st SESSION

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Hon. Kevin Sorenson
Chair

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NOTICE TO READER

Reports from committee presented to the House of Commons

Presenting a report to the House is the way a committee makes public its findings and recommendations on a particular topic. Substantive reports on a subject-matter study usually contain a synopsis of the testimony heard, the recommendations made by the committee, as well as the reasons for those recommendations.

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THE STANDING COMMITTEE ON PUBLIC ACCOUNTS

has the honour to present its

FORTY-FIFTH REPORT

Pursuant to its mandate under Standing Order 108(3)(*g*), the Committee has studied Report 4, Oral Health Programs for First Nations and Inuit—Health Canada, of the Fall 2017 Reports of the Auditor General of Canada and has agreed to report the following:

HOUSE OF COMMONS
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REPORT 4, ORAL HEALTH PROGRAMS FOR FIRST NATIONS AND INUIT—HEALTH CANADA, OF THE 2017 FALL REPORTS OF THE AUDITOR GENERAL OF CANADA

INTRODUCTION

According to the Office of the Auditor General of Canada (OAG), "Health Canada [or the Department] supports the oral health of First Nations and Inuit populations through various programs. The largest of these is the Non-Insured Health Benefits Program [NIHBP], which reimburses claims for medically necessary health services, including oral health services."[1] Similarly, the Children's Oral Health Initiative "promotes oral health care and offers preventive oral health services for young children in about half of the eligible communities."[2]

Additionally, these programs "support the Department's mandate to ensure access to health services for First Nations and Inuit populations. Oral health surveys have found that First Nations and Inuit populations had nearly twice as much dental disease and more unmet oral health needs compared with other Canadians."[3]

The OAG further noted that "Health Canada and the Assembly of First Nations began a joint review of the Non-Insured Health Benefits Program in 2014 to respond to concerns raised by First Nations. The objective of the review, which is currently under way, is to identify and implement actions that

- enhance client access to benefits,
- identify and address gaps in benefits,
- streamline service delivery to be more responsive to client needs, and

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1 Office of the Auditor General of Canada (OAG), Oral Health Programs for First Nations and Inuit–Health Canada, Report 4 of the 2017 Fall Reports of the Auditor General of Canada, para. 4.1.

2 Ibid.

3 Ibid., paras. 4.1-4.2.

- increase program efficiencies."[4]

Per "Health Canada's policy framework, the objective of the Non-Insured Health Benefits Program's dental benefit is to provide eligible clients with access to oral health services in a fair, equitable, and cost-effective manner that will: address oral health needs and contribute to improving the oral health status of eligible First Nations and Inuit clients; and provide coverage for a range of oral health services based on professional judgment and the client's oral health status/condition, consistent with current best practices of health services delivery, and evidence-based services and standards of care."[5]

According to its annual reports, the Non-Insured Health Benefits Program "paid claims made by approximately 300,000 eligible Inuit and First Nations people annually. Some dental professionals provide oral health services on a fee-for-service basis to clients covered under the program. In some regions, Health Canada also contracts dentists directly to deliver services in First Nations and Inuit communities. The Department also uses contribution agreements to fund the delivery of oral health services to eligible First Nations and Inuit clients."[6] In 2015–2016, fee-for-service expenditures were approximately $145 million for various procedures.[7]

Regarding the Children's Oral Health Initiative, its objectives are to "reduce and prevent oral disease through prevention, education and oral health promotion" and "increase access to oral health care;" oral health education "is provided to children, their parents and caregivers, and pregnant women."[8] Furthermore, the "initiative relies on voluntary participation; it cost approximately $5.4 million in the 2014-15 fiscal year. According to Health Canada, in 2016, the initiative was provided in 238 of 452 eligible First Nations and Inuit communities. A variety of dental workers, including contract dentists, dental therapists, dental hygienists, and Children's Oral Health Initiative community workers, delivered services."[9]

In the fall of 2017, the OAG released a performance audit whose objective was to determine "whether Health Canada had reasonable assurance that its oral health

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4 Ibid., para. 4.4.

5 Ibid., para. 4.5.

6 Ibid., paras. 4.5-4.6.

7 Ibid., para. 4.8.

8 Ibid., para. 4.9.

9 Ibid.

programs for eligible Inuit and First Nations people had a positive effect on their oral health."[10]

It should be noted that resulting from "an Order-in-Council dated November 30, 2017, the First Nations and Inuit Health Branch [FNIHB] is now under the purview of the Department of Indigenous Services Canada [ISC]."[11]

On 22 March 2018, the House of Commons Standing Committee on Public Accounts (the Committee) held a hearing on this audit.[12] From the OAG were Michael Ferguson, Auditor General of Canada, and Jo Ann Schwartz.[13] From ISC were Jean-François Tremblay, Deputy Minister; Sony Perron, Associate Deputy Minister; David Peckham, Chief Audit and Evaluation Executive; and, Dr. Marc C. Plante, Manager, Dental Policy.[14]

FINDINGS AND RECOMMENDATIONS

A. Determining Effect of Dental Benefit Program on Improving Oral Health

According to the OAG, "Health Canada had information in its dental claims database that it used to understand the oral health needs of Inuit and First Nations people. It also funded surveys that gathered information about First Nations and Inuit oral health."[15] These surveys showed "that the oral health needs of Inuit and First Nations people were greater than those of the rest of the Canadian population. Notably, more than 90[%] of First Nations and Inuit adolescents had one or more teeth affected by cavities, compared with 58[%] of adolescents who were not Inuit or First Nations. Both Inuit and First Nations people were also more likely to have untreated dental issues, and fewer of them visited oral health professionals in a year."[16]

As such, Health Canada "had known for many years that Inuit and First Nations people's oral health was poor, and attempted to develop a strategic approach to improving it."[17]

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10 Ibid., para. 4.10.

11 Indigenous Services Canada, Detailed Action Plan, p. 1.

12 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 22 March 2018, Meeting 90.

13 OAG, Oral Health Programs for First Nations and Inuit–Health Canada, Report 4 of the 2017 Fall Reports of the Auditor General of Canada, para. 4.10.

14 Ibid.

15 Ibid., para. 4.25.

16 Ibid., para. 4.27.

17 Ibid., para. 4.28.

The OAG found "that the Department drafted strategic approaches to oral health in 2010 and 2015, but did not finalize them. The Department committed to the implementation of an oral health strategy and action plan in 2015 in its Report on Plans and Priorities. Department officials developed regional plans for oral health service delivery. They also continued to discuss a strategic approach to oral health, and in 2016, the Department hired a contractor to develop one."[18]

Therefore, the OAG recommended that "Health Canada should finalize and implement a strategic approach to oral health for Inuit and First Nations people, along with a detailed action plan with specific timelines, and monitor implementation."[19]

In response, ISC stated in its Detailed Action Plan that it agreed with the recommendation, and that the "finalized [Integrated Oral Health Approach] will provide strategic guidance for a holistic and collaborative approach between FNIHB, Regions, Indigenous partners, other departments;" this is to be completed by 30 June 2018.[20] Furthermore, "Senior Management Committee approval of revised Regional Oral Health Service Delivery Plans" (expected by 30 September 2018) "will have a specific focus on regional health human resources planning."[21]

When questioned about why the strategic approach was not yet in place, Jean-François Tremblay, Deputy Minister, acknowledged that there "is progress to be made," but cautioned that the national strategy will not necessarily fix everything identified in the audit.[22]

Given the importance of a sound strategic approach regarding oral health services delivery for Indigenous Canadians, the Committee recommends

Recommendation 1 - Regarding a strategy for oral health for Indigenous Canadians

That, by 30 November 2018, *Indigenous Services Canada* provide the House of Commons Standing Committee on Public Accounts with a report detailing what progress has been made with regard to 1) finalizing and implementing a strategic approach to oral health

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18 Ibid., para. 4.28.

19 Ibid., para. 4.30.

20 Indigenous Services Canada, Detailed Action Plan, p. 1.

21 Ibid.

22 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 22 March 2018, Meeting 90, 1640.

for Inuit and First Nations people, including the development and use of a detailed action plan with specific timelines; and, 2) monitoring its implementation.

Additionally, the OAG noted that although Health Canada analyzed data regarding benefits paid through the Non-Insured Health Benefits Program, it concluded that "this information would not allow the Department to determine whether the services helped to improve the oral health of Inuit and First Nations people."[23]

> CASE STUDY
>
> [The OAG] found that the Department did not have a concrete plan to determine how much of a difference the Non-Insured Health Benefits Program's dental benefit was making. This plan could include determining the information the Department needs to assess the impact of the services, how often it should be collected, and how this information could be used to adjust the dental benefits or other programs to achieve better outcomes. According to the Department, because the program covered evidence-based dental services, it is having a positive effect on its clients' oral health. Furthermore, Department officials explained that they depend on the oral health surveys that are carried out periodically (discussed in paragraphs 4.25 to 4.27) to provide the Department with information on Inuit and First Nations people's oral health.
>
> Source: Office of the Auditor General of Canada, Oral Health Programs for First Nations and Inuit— Health Canada, Report 4 of the 2017 Fall Reports of the Auditor General of Canada, para. 4.34.

As reported by the OAG, the "Treasury Board's Policy on Results states an expectation that departments be clear on what they are trying to achieve and how they will assess success;" consequently, given that an objective of the program is to contribute to maintaining and improving First Nations and Inuit health, the OAG concluded that determining "whether there were any improvements in Inuit and First Nations people's oral health could help the Department meet these objectives."[24]

Lastly, the OAG found that although the Department "collected information in various databases on Non-Insured Health Benefits Program claims, Children's Oral Health Initiative services, dental therapy services, and contract dentists, the Department did

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23 OAG, Oral Health Programs for First Nations and Inuit–Health Canada, Report 4 of the 2017 Fall Reports of the Auditor General of Canada, para. 4.32.

24 Ibid., para. 4.33.

not regularly analyze this data together to determine whether its programs and benefits improved oral health."[25]

Thus, the OAG recommended that "Health Canada should develop a concrete plan to determine how much of a difference its oral health services are making on the oral health of Inuit and First Nations people. This plan should use all the relevant information the Department collects, and should include a collaboration among all of Health Canada's programs involved in oral health."[26]

In response, ISC stated in its Detailed Action Plan that it agreed with the recommendation and that to "ensure that the Department has population-level oral health data, the Public Health Agency of Canada, Statistics Canada and First Nations and Inuit partners will be engaged to explore a population-based oral health survey approach."[27] Additionally, to "ensure that the data collected by the Department is being analyzed and reported on in a robust and reliable manner, the Department engaged the [Non-Insured Health Benefits Oral Health Advisory Committee] to review the data collected."[28]

Jean-François Tremblay, Deputy Minister, added that the success of these programs depends on continued partnerships with Indigenous peoples, and that "changes in health cannot be imposed on anyone; they must come from people. So the changes must be planned in partnership with indigenous people. In the long run, these changes should ideally be developed by indigenous authorities."[29]

In light of the importance the Committee places on sound data collection and use, especially regarding measuring the effectiveness of health care programs for Indigenous Canadians, it thus recommends

Recommendation 2 - Regarding improving data collection

That, by 30 November 2018, *Indigenous Services Canada* provide the House of Commons Standing Committee on Public Accounts with a report detailing what progress has been

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25 Ibid., para. 4.35.

26 Ibid., para. 4.37.

27 Indigenous Services Canada, Detailed Action Plan, pp. 1-2.

28 Ibid. According to ISC, the Committee "is an independent body composed of clinical and academic experts, including First Nations and Inuit dental professionals."

29 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 22 March 2018, Meeting 90, 1700.

made with regard to developing a concrete plan to determine how much of a difference its oral health services are making on the oral health of Inuit and First Nations people.

B. Data and Analysis Pertaining to the Children's Oral Health Initiative

The OAG found that the "Children's Oral Health Initiative provides access to important preventive services that help children maintain and improve their oral health" and that the Department analyzed program data and "determined that it had had a positive effect on the oral health outcomes of participating children in the communities where it was offered. However, departmental data also showed that the number of children enrolled in the initiative had declined over the past three years along with the numbers of services provided," and was unsure of its cause.[30]

According to the OAG, in 2017, "the Department drafted a strategy to address its data collection issues, but the strategy has yet to be finalized. The Department has recognized that the current dental database requires fundamental changes before it can be used for proper data collection, analysis, and reporting. This would be an even greater challenge if the Children's Oral Health Initiative were expanded."[31]

Hence, the OAG recommended that "Health Canada should improve its analysis of data, including the information that is collected and recorded in its dental database, so that its information on the Children's Oral Health Initiative is accurate and comprehensive enough to contribute to the Department's overall management of its oral health programs."[32]

In response, ISC stated in its Detailed Action Plan that it agreed with the recommendation and that it will implement the "Strategies to Improve Oral Health Data Collection, Analysis, and Reporting for First Nations and Inuit Health Branch's dental programs to inform program management decision making in alignment with the Oral Health Integrated Approach;" also, ISC will "collaborate with partners to identify priority action items."[33]

When questioned about this situation, Sony Perron, Assistant Deputy Minister provided the following:

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30 OAG, Oral Health Programs for First Nations and Inuit–Health Canada, Report 4 of the 2017 Fall Reports of the Auditor General of Canada, para. 4.38.

31 Ibid., para. 4.46.

32 Ibid., para. 4.47.

33 Indigenous Services Canada, Detailed Action Plan, pp. 2-3.

> There are a number of programs and different ways to collect information. For example, the children's oral health initiative depends on the work that is done in each of the 200 communities, in day-to-day services, to record the service provided, the oral health of the child, and a measurement of the progression in terms of the quality of the oral health. This requires collaboration to make sure that the data collected in northern Manitoba will be consistent with the data collected in northern Quebec.
>
> [We] have many programs, and we need to be able to link this data together. The working group is made up of people from the various programs. It's to try to harmonize the way they collect the data and organize the data. It's to provide training and also to use external experts to advise us. In the introductory remarks, we talked a little about the expert group, which is independent. They give us guidance on how we can make this happen. This working group is charged with implementing these measures.[34]

As stated previously, the Committee considers the proper collection and use of data to be a priority issue, and thus recommends

Recommendation 3 - Regarding improving data analysis

That, by 30 November 2018, *Indigenous Services Canada* provide the House of Commons Standing Committee on Public Accounts with a report detailing what progress has been made with regard to improving its analysis of data, including the information that is collected and recorded in its dental database, to ensure that information on the Children's Oral Health Initiative is accurate and comprehensive enough to contribute to ISC's overall management of its oral health programs.

C. How Health Canada Changed its List of Dental Benefits

According to the OAG, "Health Canada had a list of oral health services covered by the Non-Insured Health Benefits Program. Some of the eligible services included specific criteria to define when the service was necessary. For example, to qualify for a crown or a root canal, an individual would have to meet detailed medical criteria that set out which teeth were eligible and under what conditions. Some services were also subject to controls, such as frequency limits or a requirement for pre-approval. The list of eligible services, their criteria, and their controls were published on the Department's website."[35]

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34 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 22 March 2018, Meeting 90, 1605.

35 OAG, Oral Health Programs for First Nations and Inuit–Health Canada, Report 4 of the 2017 Fall Reports of the Auditor General of Canada, para. 4.58.

Additionally, although the OAG acknowledged that Health Canada "had documented the process it used to decide whether to make changes to the list of eligible oral health services covered by the Non-Insured Health Benefits Program," it did "not identify what Department officials should consider when deciding whether to make such changes;" nor did "the process clearly indicate how decisions should be documented or who should approve them, in some cases."[36]

The OAG also noted that between "2014 and 2016, the Department made decisions to change some of the oral health services it covered. These decisions were largely about changing controls. For example, some decisions [the OAG examined] increased the limits on how frequently a service could be covered, while others removed the pre-approval requirement for certain services;" Health Canada asserted that they were implemented to improve client access to services.[37]

The OAG "found inconsistencies in how the Department documented the 13 decisions it made in that period: While 8 had signed records of decision, 5 did not, meaning that we could not determine when or by whom those decisions were made. Furthermore, the documentation of the factors that were considered varied; for example, the documentation for only some of the changes clearly showed the expected effects of the proposed changes on costs."[38] And it also found that "Health Canada did not promptly inform clients and service providers about three of the changes it made to its services in that period."[39]

Therefore, the OAG recommended that "Health Canada's process for making changes to its list of oral health services covered by the Non-Insured Health Benefits Program should

- include which elements should be considered,
- include requirements to document when and how decisions are made,
- specify who has final approval for all such decisions, and
- include quickly updating providers and clients on changes."[40]

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36 Ibid., para. 4.59.

37 Ibid., para. 4.60.

38 Ibid., para. 4.61.

39 Ibid., para. 4.62.

40 Ibid., para. 4.63.

In response to this recommendation, ISC agreed and in its action plan, stated that it "has detailed documentation in place, such as its Dental Benefits Policy Framework: NIHB and evidence-based guidelines, to govern decision making related to dental benefits. One of these documents—the Policy Review and Development Process for Dental Benefits—has been revised in light of the findings of this audit to be more specific about the elements that must be considered when making policy changes."[41] In addition, ISC commits to "strive to ensure that clients and providers are informed in a more timely manner," and that it will "develop a client provider communications process map."[42]

When questioned about this matter, Jean-François Tremblay, Deputy Minister, provided the following:

> We're working with first nations and Inuit communities and organizations in trying to find ways to ensure that we actually reach out to and communicate to our partners and the clients. We're talking about a potential 853,000 clients at the moment, dispersed across the country, on and off reserve, so it's a vast population. For us, it means that we've been working with communities, the primary health care centres that exist in the communities, and the health professionals, and also, of course, potentially working with social media to make sure that clients have access to the most information perspectives possible. We also have newsletters that inform people about what we're doing, and that's something that we are looking at improving.[43]

Furthermore, Dr. Marc Plante, Manager, Dental Policy, added the following:

> We're also working with the Canadian Dental Association. Whenever we make changes now, they also publish them, sometimes on their website, and there are the other associations also, such as the Denturist Association of Canada and the Canadian Dental Hygienists. They're helping us by trying to spread the word throughout the providers, but also on the client side, because they also see the clients in their offices. There's a lot of work to be done, for sure.[44]

To help ensure that ISC implements improved methods of communicating changes to oral health programs, the Committee therefore recommends

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41 Indigenous Services Canada, Detailed Action Plan, p. 3.

42 Ibid.

43 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 22 March 2018, Meeting 90, 1630.

44 Ibid., 1635.

Recommendation 4 - Regarding communicating changes to oral health programs

That, within 120 days of the presenting of this report, *Indigenous Services Canada* provide the House of Commons Standing Committee on Public Accounts with a report detailing what progress has been made with regard to improving the process for making changes to its list of oral health services covered by the Non-Insured Health Benefits Program.

D. Clarity of Health Canada's Service Standards for Pre-approvals and Complex Appeals

According to the OAG, in 2015–16, "4[%] of the oral health services the Non-Insured Health Benefits Program paid for required pre-approval. Health Canada had a published service standard specifying that the program would make pre-approval decisions within 10 business days from the date of receipt of complete information;" as such, "Health Canada's clients could interpret this service standard as a commitment to provide each client with a decision within 10 business days. In fact, Health Canada does not measure its service standard by individual client. Health Canada indicated that information on turnaround times for individual cases was readily available and could be provided to clients if they contacted the Department directly."[45]

The OAG also found that "Health Canada published a service standard of 30 business days to make a decision about an appeal. Health Canada has stated that complex appeals can take longer to process, but did not clearly explain what constitutes a complex appeal. Without this explanation, clients cannot know whether their appeals are 'complex,' and therefore, how long they should expect to wait for a response."[46]

It should be noted that among the OAG's sample of 85 appeals cases, their corresponding database entries contained numerous administrative errors; for example, 30% of dates had been entered incorrectly.[47] Nevertheless, the OAG was able to conclude that "Health Canada had processed 80% of sampled cases within the service standard."[48]

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45 OAG, Oral Health Programs for First Nations and Inuit–Health Canada, Report 4 of the 2017 Fall Reports of the Auditor General of Canada, para. 4.69.

46 Ibid., para. 4.70.

47 Ibid., para. 4.71.

48 Ibid.

Thus, the OAG recommended that in order to "improve its program management for the Non-Insured Health Benefits Program dental benefit, Health Canada should

- clarify what its service standard for pre-approvals is measuring;
- clarify the service standard for complex appeals; and
- improve its data entry, so that it has accurate and reliable information in its appeal database."[49]

In response, ISC stated in its Detailed Action Plan that it agrees with the recommendation and states that both the definition of service standard for pre-approvals and the term "complex appeals" are under review.[50] Furthermore, ISC plans to

- "review its program management processes and will develop communications for clients, partners, and providers regarding its timelines for reviewing predeterminations and appeals."[51]
- "continue to improve data entry accuracy pertaining to its administrative appeals database. The procurement process for the new Health Information and Claims Processing Services system is looking to integrate the appeals process within this system."[52]

Further to this last point, Jean-François Tremblay, Deputy Minister, explained that "[quality] assurance processes are currently being developed and implemented to ensure improved data entry in the appeals database."[53]

To help ensure the sound management of the NIHBP dental benefit, the Committee recommends

Recommendation 5 - Regarding improving program management

That, within 120 days of the presenting of this report, *Indigenous Services Canada* provide the House of Commons Standing Committee on Public Accounts—pertaining to

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49 Ibid., para. 4.72.

50 Indigenous Services Canada, Detailed Action Plan, pp. 3-4.

51 Ibid.

52 Ibid.

53 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 22 March 2018, Meeting 90, 1545.

improving the management of the Non-Insured Health Benefits Program dental benefit—a report detailing what progress has been made with regard to 1) clarifying what its service standard for pre-approvals is measuring; 2) clarifying the service standard for complex appeals; and, 3) improving its data entry, so that it has accurate and reliable information in its appeal database.

E. Health Canada's Response to Human Resources Challenges

According to the OAG, "Health Canada uses various types of service providers across seven of its regions. The Department relies primarily on dentists to provide services, but it cannot require them to participate in the Non-Insured Health Benefits Program; nor can it plan for the number of providers who register with the program."[54] The Department "tried to address the lack of local dental providers by using contract dentists."[55]

However, the OAG found that one of the two regions "examined had determined that not enough contract dentists were available to provide services in the communities it served."[56] Additionally, it "had not analyzed the costs and benefits of using contract dentists relative to other types of service providers."[57]

The OAG also noted that "Health Canada also used dental therapists to provide services in communities in four of seven of its regions. Dental therapists in these communities focus primarily on the needs of children, but can also provide services to adults. According to the Department, as of the end of 2016, Health Canada relied on 82 community-based dental therapists, employed by either the Department or the communities, to deliver Children's Oral Health Initiative services in collaboration with the initiative's community workers."[58]

Lastly, "Health Canada had known about the impending high rate of retirements of dental therapists for several years and started to develop strategies to address this in 2009."[59] However, the OAG found that although "one region had recently requested

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54 OAG, Oral Health Programs for First Nations and Inuit–Health Canada, Report 4 of the 2017 Fall Reports of the Auditor General of Canada, para. 4.78.

55 Ibid., para. 4.79.

56 Ibid., para. 4.80.

57 Ibid., para. 4.81.

58 Ibid., para. 4.82.

59 Ibid., para. 4.84.

funds for some of these strategies," it was not the case for the other region, "despite the fact that several dental therapist positions were already vacant."[60]

Hence, the OAG recommended that "Health Canada should implement strategies to ensure that it has the human resources it needs to deliver oral health programs and related services to First Nations and Inuit populations over the long term. These strategies could incorporate the use of a variety of professionals and adopt practices from other regions, where applicable."[61]

In response, ISC agreed with this recommendation and stated in its Detailed Action Plan that it "will ensure that foreseeable shortages are addressed through contingency plans developed by regions facing such a challenge."[62] Moreover, to "ensure awareness of the [ISC] Oral Health Programs to oral health providers, [ISC] officials will have a presence at oral health professions conferences and educational institutions."[63]

On the subject of human resources challenges pertaining to the delivery of oral health services for Indigenous communities, and ISC's plans to better address them, Sony Perron, Assistant Deputy Minister, provided the following:

> What we have to work on is the stabilization of the service provider community in order to make sure that the same dentist or the same dental therapist visits the community. When there is a disruption, there might be difficulty in following up with the client. It's about investing in local workers as well and doing it with the community, so that there is someone locally who is in charge of doing the follow-up and calling back the clients to make sure they show up when the dentist comes.[64]

Given the importance of addressing shortages that could affect oral health services delivery, especially for Canada's Indigenous peoples, the Committee recommends

Recommendation 6 - Regarding human resources strategies

That, by 31 January 2019, *Indigenous Services Canada* provide the House of Commons Standing Committee on Public Accounts with a report detailing what progress has been made with regard to implementing strategies to ensure that it has the human resources

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60 Ibid.

61 Ibid., para. 4.85.

62 Indigenous Services Canada, Detailed Action Plan, pp. 4-5.

63 Ibid.

64 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 22 March 2018, Meeting 90, 1650.

it needs to deliver oral health programs and related services to First Nations and Inuit populations over the long term.

CONCLUSION

The Committee concludes that although "Health Canada provided Inuit and First Nations people with access to important oral health services, the Department did not demonstrate how much its oral health programs helped maintain and improve the overall oral health of Inuit and First Nations at the population level."[65] Acknowledging that responsibility of administering these programs has now been transferred to Indigenous Services Canada, the Committee has made six recommendations in this report to help ensure ISC implements improvements for the betterment of Indigenous Canadians.

65 OAG, Oral Health Programs for First Nations and Inuit–Health Canada, Report 4 of the 2017 Fall Reports of the Auditor General of Canada, para. 4.86.

SUMMARY OF RECOMMENDED ACTIONS AND ASSOCIATED DEADLINES

Table 1 – Summary of Recommended Actions and Associated Deadlines

Recommendation	Recommended Action	Deadline
Recommendation 1	*Indigenous Services Canada* (ISC) should provide the House of Commons Standing Committee on Public Accounts (the Committee) with a report detailing what progress has been made with regard to 1) finalizing and implementing a strategic approach to oral health for Inuit and First Nations people, including the development and use of a detailed action plan with specific timelines; and, 2) monitoring its implementation.	30 November 2018
Recommendation 2	ISC should provide the Committee with a report detailing what progress has been made with regard to developing a concrete plan to determine how much of a difference its oral health services are making on the oral health of Inuit and First Nations people.	30 November 2018
Recommendation 3	ISC should provide the Committee with a report detailing what progress has been made with regard to improving its analysis of data, including the information that is collected and recorded in its dental database, to ensure that information on the Children's Oral Health Initiative is accurate and comprehensive enough to contribute to ISC's overall management of its oral health programs.	30 November 2018

Recommendation	Recommended Action	Deadline
Recommendation 4	ISC should provide the Committee with a report detailing what progress has been made with regard to improving the process for making changes to its list of oral health services covered by the Non-Insured Health Benefits Program.	Within 120 days of the presenting of this report
Recommendation 5	ISC should provide the Committee—pertaining to improving the management of the Non-Insured Health Benefits Program dental benefit—a report detailing what progress has been made with regard to 1) clarifying what its service standard for pre-approvals is measuring; 2) clarifying the service standard for complex appeals; and, 3) improving its data entry, so that it has accurate and reliable information in its appeal database.	Within 120 days of the presenting of this report
Recommendation 6	ISC should provide the Committee with a report detailing what progress has been made with regard to implementing strategies to ensure that it has the human resources it needs to deliver oral health programs and related services to First Nations and Inuit populations over the long term.	31 January 2019

APPENDIX A
LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
Department of Indian Affairs and Northern Development	2018/03/22	90
Jean-François Tremblay, Deputy Minister		
Sony Perron, Assistant Deputy Minister		
David Peckham, Chief Audit and Evaluation Executive, Audit and Evaluation Sector		
Marc C. Plante, Manager Dental Policy, First Nations and Inuit Health Branch		
Office of the Auditor General		
Michael Ferguson, Auditor General of Canada		
Jo Ann Schwartz, Principal		

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant *Minutes of Proceedings* (Meetings Nos. 90 and 94) is tabled.

Respectfully submitted,

Hon. Kevin Sorenson
Chair